BENEFIT CHANGE FORM

This form is NOT to be used for any COBRA event.
Use Benefit Termination Notice instead.

City of Gulfport
1410 24th Avenue
Gulfport, MS 39501
228.868.5831 office
228.868.5833 fax

GROUP NAME			GROUP NUMBER
City of Gulfport			Plan # ***10609***
EMPLOYEES LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

(1) ☐ APPLICATION FOR ADDITION OF DEPENDENTS

(2) ☐ DELETION OF EMPLOYEE COVERAGE

(3) ☐ DELETION OF DEPENDENT COVERAGE: **Must have qualifying event and provide documentation, unless deletion is done during open enrollment.**

Please list dependents after checking this box.
Check appropriate Coverage box for each dependent.

EFFECTIVE DATE OF EVENT:_____

EFFECTIVE DATE OF ADDITION/DELETION: _____

CIRCLE TYPE OF EVENT

(A) For eligible spouse – give date of marriage
(B) For adopted child – give date of legal adoption or date appointed guardian – Attach copy of adoption or guardianship papers.
(C) For child acquired by marriage – give date of marriage.
(D) For birth of child – give date of birth and certificate of live birth (must be provided within 31 days of birth.
(E) For loss of Job/Coverage – give date of loss of job- Provide Certificate of Insurance

EMPLOYEE AND/OR DEPENDENT INFORMATION
COMPLETE FOR EACH PERSON TO BE COVERED OR DELETED FROM THE PLAN

FULL NAME	SEX M/F	DATE OF BIRTH MO	DAY	YEAR	SOCIAL SECURITY NUMBER	COVERAGE REQUESTED
EMPLOYEE						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
SPOUSE						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
CHILDREN 1.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
2.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
3.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
4.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
5.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
6.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision

(4) ☐ CHANGE OF NAME: (must provide copy of social security card)	FROM:		TO:	
(5) ☐ CHANGE OF ADDRESS:	FROM:		TO:	
(6) ☐ TRANSFER TO NEW DIVISION:	FROM:		TO:	
(7) ☐ OTHER CHANGE TO RECORD:	FROM:		TO:	

Employee Signature:_____ Date Signed:_____

Personnel Use Only

Entered By: _____ Date Entered into MUNIS: _____

Revised 1/ 2009